California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
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www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

CLINIC PERMIT APPLICATION

Please print or type **All blanks must be completed. If not applicable enter N/A**

Name of Clinic:	Clinic telephone number:

Address of Clinic: Number and street City State Zip Code

Type of Clinic: ☐ Free ☐ Multi-Specialty ☐ Community —— Non Profit ☐ Other
—— Profit
☐ Surgical ☐ Ambulatory Surgical

Indicate whether this application is for:
☐ New Clinic ☐ Change of Location ☐ Change of Ownership

If change of ownership or change of location, indicate previous name, address and license number of clinic:

Type of ownership:
☐ Individual ☐ Partnership ☐ Corporation ☐ Government

Date of last inspection by the Department of Health Services:	Are you Medicare Certified? If yes, attach a copy of your current medicare certificate. ☐ Yes ☐ No

Anticipated first day of business:

Mail all correspondence to the following address below. If correspondence should be mailed to the clinic please insert "Same as Clinic."

Name and telephone number of contact person to clarify information provided on this application.

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Continue on reverse

For Office Use Only

Staff Review			Cashier
☐ Articles of Inc ☐ Partner Agreement ☐ Seller's Cert ☐ DHS Insp Report	☐ DHS license ☐ Policy & Proc ☐ Medicare cert	Approval_____ Denied_____ Date_____	Cashiering #_____ Date_____ Amount of Fee_____
Date referred:			

Ownership Information

Name of Sole Owner (If applicable)			*Social Security Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Partner (If applicable)			*FEIN Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Partner (If applicable)			*FEIN Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Corporation (If applicable)					Telephone Number
Address	number and street	City		State	Zip Code

Print below the name, title, address and license number of all the clinic owners. This includes the individual owner, all partners, corporate officers. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian etc., and license number. Non-profit organizations must list the names and titles of persons holding corporate positions. Attach additional sheet if necessary.

Title	Name	Residence Address	Licensed as and license number

*Disclosure of your social security number (or federal employer identification number ("FEIN"), if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

Name of Professional Director:			License Number
Residence Address	City	State	Zip Code
Name of Administrator:			License Number
Residence Address	City	State	Zip Code
Name of Consulting pharmacist:			License Number
Residence Address	City	State	Zip Code

I certify that the policies and procedures of the clinic's drug distribution service are consistent with the promotion and protection of health and safety of the public regarding inventories, security, training, protocol development, recordkeeping, packaging, labeling dispensing, and patient consultation.

Signature of Consulting Pharmacist	Name (please print)	Date

PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a clinic permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) the clinic complies with all applicable laws and regulations of the State Department of Health Services relating to drug distribution (Title 22, Article 4); (5) the professional director is responsible for safe, orderly and lawful provisions of the pharmacy service; (6) all supplemental statements are true and accurate. I am also aware that I am bound by the applicable Federal and State laws and regulations pertaining to the practice of pharmacy; and (7) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Signature of Professional Director	Name (please print)	Title	Date
Signature of Administrator	Name (please print)	Title	Date
Signature of Corporate officer, owner, or partner	Name (please print)	Title	Date
Signature of Corporate officer, owner, or partner	Name (please print)	Title	Date

17A-42 (Rev. 1/01)